Missouri Medicaid Psychology/Counseling Billing Book

Missouri Department of Social Services
Division of Medical Services

Published by the Provider Education Unit

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Preface

This psychology/counseling training booklet contains information to help providers submit claims correctly. The information is only for Missouri Medicaid providers and billers if the provider's Medicaid provider number begins with "49". The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for the entire content.

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SECTION 1
MEDICAID PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call the Provider Communications Unit with provider inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The toll free line provides an interactive voice response system that can answer questions regarding matters including recipient eligibility, last two check amounts, and claim status. Providers must use a touchtone phone to access the system.

Provider Communications	573/751-2896
Interactive Voice Response (IVR)	573/635-8908

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102

INFOCROSSING HEALTHCARE SERVICES HELP DESK

573/635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements, and assistance with the Infocrossing Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via e-mail as follows for questions regarding enrollment applications: providerenrollment@dss.mo.gov.

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare number must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
P.O. Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
573/751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid patient.

PROVIDER EDUCATION
573/751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES
800/392-2161 or 573/751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services, and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE
800/392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is 573/636-6470.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) INFORMATION

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA Companion Guide* online by going to the Division of Medical Services Web page at www.dss.mo.gov/dms and clicking on “manuals” under the Provider Information heading.

To access the *X12N Version 4010A1 Companion Guide*: 1) select Missouri Medicaid Electronic Billing Layout Manuals; 2) select System Manuals; 3) select Electronic Claims Layout Manuals; and, 4) select X12N Version 4010A1 Companion Guide.

For information on the Missouri Medicaid Trading Partner Agreement: 1) select Section 1 - Getting Started; and, 2) select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Infocrossing Help Desk, 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR)
573/635-8908

The Provider Communications Unit Interactive Voice Response (IVR) system, 573/635-8908, requires a touchtone phone. The nine-digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 Recipient Eligibility

Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth; or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 Claim Status

After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Infocrossing Healthcare Services, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit adjustments;
- Submit attachments; and
- View and download public files.

The Web site address for this service is www.emomed.com. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the Web site services. To participate in the service, the provider must apply on-line through the DMS Web site. Each user is required to complete this on-line application in order to obtain a user ID and password. The application process only takes a few minutes and provides the applicant with a real-time confirmation response, user ID, and password. Once the user ID and password have been received, the user can begin using the www.emomed.com Web site. The password can be changed to one of the user's own choice.

Questions regarding the completion of the on-line Internet application should be directed to the Infocrossing Healthcare Services Help Desk, (573) 635-3559.

An authorization is required for each individual person within a provider's office or a billing service who will be accessing the Internet site.

This Web site, www.emomed.com, allows for the submission of the following HIPAA compliant transactions:

837 Institutional Claims	Batched or Individual
837 Professional Claims	Batched or Individual
837 Dental Claims	Batched or Individual
270 Eligibility Inquiry	Batched or Individual
276 Claim Status Inquiry	Batched or Individual

The following standard responses are generated:

835 Remittance Advice	Batch or Printable RA
271 Eligibility Response	Batch or Individual
277 Claim Status Response	Batch or Individual

Users also have access to provider check amounts and the Claims Processing Schedule for the current fiscal year.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements. However, the user (provider) must have the proper Web browser. The provider must have one of the following Web browsers: Internet Explorer 6.0 or higher or Netscape 7.0 or higher. It is strongly recommended that users update and utilize the most recent versions of either of these browser programs. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the Web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occurs in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

NOTE: Currently, some claims cannot be submitted electronically if an attachment is required unless the attachment is one of the following that can be submitted via the Infocrossing Internet service: Sterilization Consent, Second Surgical Opinion, Acknowledgment of the Receipt of Hysterectomy Information or the PI 118 Referral forms.

OBTAINING A REMITTANCE ADVICE THROUGH THE INTERNET

The Medicaid program phased out the mailing of paper Remittance Advices (RAs). Providers no longer receive both paper and electronic RAs. If the provider or the provider's billing service currently receive an electronic RA, (either via the emomed.com Internet Web site or other method), paper copies of the RA were discontinued as of the July 20, 2004 financial cycle. All providers and billers must have Internet access to obtain the printable electronic RA via the Infocrossing Internet service, emomed.com.

Receiving the remittance advice via the Internet is beneficial to the provider's or biller's operation. With the new Internet RA, a user can:

- Retrieve the RA the Monday following the weekend claim processing cycle (two weeks sooner than receipt of the paper RA);
- Have access to RAs for 62 days (the equivalent of the last four cycles);
- View and print the RA from the desktop; and,
- Download the RA into the provider's or biller's operating system for retrieval at a later date.

The Internet RA is viewable and printable in a ready to use format. Just point and click to print the RA or save it to the computer system for printing at the user's convenience.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 - Replacement (Adjustment) or an 8 - Void (Credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the Web site including the claims processing schedule for the State fiscal year which begins July 1 and ends June 30. Providers also have access to a listing of HIPAA related claim codes and other HIPPAA related codes.

SUBMIT ATTACHMENTS AND FORMS THROUGH THE INTERNET

Providers can submit required attachments and forms via the Internet as an option to mailing paper versions to Medicaid. A paper copy of any attachment or form submitted via the Internet must be kept with the patient's record. The following forms can be submitted through the Infocrossing Internet Service:

Sterilization Consent,
Second Surgical Opinion,
PI 118 Referral (administrative lock-in), and
Acknowledgment of Receipt of Hysterectomy Information.

MEDICAID PROVIDER MANUALS ON-LINE
www.dss.mo.gov/dms

Missouri Medicaid provider bulletins are available on-line at the DMS Web site: www.dss.mo.gov/dms. The bulletins are published to notify providers of new program and policy changes or to clarify existing policy. The bulletins appear on-line at the Provider Bulletin location until the manuals are updated. Once the manuals are updated, the bulletins are moved to the Archived Bulletin location.

Missouri Medicaid Provider manuals are also available on-line at the DMS Web site. The provider manual information you download is current as of the time it is downloaded. Since periodic updates are made to the manuals, you must do a new download periodically so that your file will have the new or updated information. In order to be able to download and use all or a portion of an on-line Medicaid provider manual or bulletins, you must have Adobe Acrobat Reader. You may already have Adobe Acrobat Reader loaded on your computer.

CLAIM AND ATTACHMENT MAILING ADDRESSES

Medicaid paper claims and attachments related to claims must be sent to the following address as indicated.

Infocrossing Healthcare Services, Inc.
P.O. Box (see below for correct PO box number)
Jefferson City, MO 65102

P.O. Box 5200……. RHC Claims
P.O. Box 5600……. DME, HCFA-1500, and Home Health Agency Claims
P.O. Box 4800……. Prior Authorization Requests

Infocrossing's physical address is: Infocrossing Healthcare Services, Inc.
905 Weathered Rock Road
Jefferson City, MO 65101

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2006

Cycle Run/Remittance Date* -	Check Date -
Friday, June 17, 2005	Tuesday, July 05, 2005
Friday, July 08, 2005	Wednesday, July 20, 2005
Friday, July 22, 2005	Friday, August 05, 2005
Friday, August 05, 2005	Monday, August 22, 2005
Friday, August 19, 2005	Tuesday, September 06, 2005
Friday, September 09, 2005	Tuesday, September 20, 2005
Friday, September 23, 2005	Wednesday, October 05, 2005
Friday, October 07, 2005	Thursday, October 20, 2005
Friday, October 21, 2005	Monday, November 07, 2005
Friday, November 04, 2005	Monday, November 21, 2005
Friday, November 18, 2005	Monday, December 05, 2005
Friday, December 09, 2005	Tuesday, December 20, 2005
Friday, December 23, 2005	Thursday, January 05, 2006
Friday, January 06, 2006	Friday, January 20, 2006
Friday, January 20, 2006	Monday, February 06, 2006
Friday, February 10, 2006	Tuesday, February 21, 2006
Friday, February 24, 2006	Monday, March 06, 2006
Friday, March 10, 2006	Monday, March 20, 2006
Friday, March 24, 2006	Wednesday, April 05, 2006
Friday, April 07, 2006	Thursday, April 20, 2006
Friday, April 21, 2006	Friday, May 05, 2006
Friday, May 05, 2006	Monday, May 22, 2006
Friday, May 19, 2006	Monday, June 05, 2006
Friday, June 09, 2006	Tuesday, June 20, 2006

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Infocrossing, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

State Holidays

July 4, 2005 Independence Day
September 5, 2005 Labor Day
October 10, 2005 Columbus Day
November 11, 2005 Veteran's Day
November 24, 2005 Thanksgiving
December 26, 2005 Christmas

January 2, 2006 New Year's Day
January 16, 2006 Martin Luther King Day
February 13, 2006 Lincoln's Birthday
February 20, 2006 Washington's Birthday
May 8, 2006 Truman's Birthday
May 29, 2006 Memorial Day

SECTION 2
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at **www.dss.mo.gov/dms**.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicate a field is required in specific situations.

Field number and name		Instructions for completion
1.*	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes.
1a.*	Insured's I.D.	Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card.
2.*	Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the ID card.
3.	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.**	Insured's Name	If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

Field number and name		Instructions for completion
6.**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.
9.**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. [See Note (1)]
9a.**	Other Insured's Policy or Group Number	Enter the secondary policyholder's insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
9c.**	Employer's Name	Enter the secondary policyholder's employer's name. If no private insurance is involved, leave blank. [See Note (1)]
9d.**	Insurance Plan	Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]

Field number and name	Instructions for completion
10a.-10c.** Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. *If the services are not related to an accident, leave blank.* [See Note (1)]
10d. Reserved for Local Use	May be used for comments/descriptions.
11.** Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. [See Note (1)]
11a.** Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. [See Note (1)]
11b.** Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. [See Note (1)]
11c.** Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* [See Note (1)]
11d.** Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. [See Note (1)]
12. Patient's Signature	Leave blank.
13. Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the

Field number and name		Instructions for completion
		provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.
14.**	Date of Current Illness, Injury or Pregnancy	This field is required when billing global prenatal and delivery services. The date should reflect the last menstrual period (LMP).
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.**	Name of Referring Physician or Other Source	Enter the name of the referring physician. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
17a.**	I.D. Number of Referring Physician	Enter the referring physician's Medicaid provider number. If the physician is nonparticipating in the Missouri Medicaid Program, enter "nonparticipating." *This field is required for independent laboratories and independent radiology groups (provider types 70 and 71), and providers with a specialty of "30" (radiology/radiation therapy).*
18.**	Hospitalization Dates	If the services on the claim were provided in an in-patient hospital setting, enter the admit and discharge dates. If the patient is still in the hospital at the time of filing, write "still" in the discharge date field or show the last date of in-patient service that is being billed in field 24a. This field is required when the service is performed on an in-patient basis.
19.	Reserved for Local Use	Providers may use this field for additional remarks/descriptions.

Field number and name	Instructions for completion
20.** Lab Work Performed Outside Office	If billing for laboratory charges, mark the appropriate box. The referring physician may **not** bill for lab work that was referred out.
21.* Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.** Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23. Prior Authorization Number	Leave blank**.**
24a.* Date of Service	Enter the date of service under "from" in month/day/year format, using a six-digit format. All line items **must** have a from date. A "to" date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
24b.* Place of Service	Enter the appropriate place of service code. See Section 15.10 of the Medicaid *Physician's Provider Manual* for the list of appropriate place of service codes.
24c. Type of Service	Leave blank.
24d.* Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (Field 19 may be used for remarks or descriptions.) See Section 7 of this booklet for a list of modifiers used by the Missouri Medicaid program.
24e.* Diagnosis Code	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.

Field number and name	Instructions for completion
24f.* Charges	Enter the provider's usual and customary charge for each line item. This should be the total charge if multiple days or units are shown.
24g.* Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a "1" if the field is left blank.
24h.** EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter "E." If the service is family planning related, enter "FP." If the service is both an EPSDT/HCY and Family Planning service enter "B."
24i. Emergency	Leave blank.
24j. COB	Leave blank.
24k.** Performing Provider Number	This field is required only for a clinic (group practice), FQHC, public health agency, teaching institution or independent radiology group. Enter the Missouri Medicaid provider number of the physician or other professional who performed the service.
25. SS#/Fed. Tax ID	Leave blank.
26. Patient Account Number	For the provider's own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27. Assignment	Not required on Medicaid claims.
28.* Total Charge	Enter the sum of the line item charges.
29.** Amount Paid	Enter the total amount received by all other insurance resources. **Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30. Balance Due	Enter the difference between the total charge (field 28) and the insurance amount paid (field 29).

Field number and name		Instructions for completion
31.	Provider Signature	Not Required.
32.**	Name and Address of Facility	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
33.*	Provider Name/ Number /Address	Affix the provider label or write or type the information **exactly** as it appears on the label.

* These fields are mandatory on all CMS-1500 claim form.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid *Provider's Manual* for further TPL (Third Party Liability) information.

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

SECTION 3
THE REMITTANCE ADVICE

Missouri Medicaid discontinued printing and mailing paper Remittance Advices (RAs) to most providers effective July 20, 2004. The remittance advices now are available via the Internet through emomed.com. There are two versions available, the 837 format and the Printable RA.

With the implementation of Internet Remittance Advice, providers can:

- Retrieve a remittance advice the Monday following the weekend Financial Cycle run (two weeks sooner than the paper version);
- View and print the RA from your desktop; and
- Download the RA into your computer system for future reference.

More information on accessing and using the printable RA is found later in this section.

When a claim is adjudicated, it is included as a line item on the next RA. Along with listing the claim, the RA lists an "Adjustment Reason Code" to explain a payment, denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payer's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from the same national administrative code set that indicates either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code. The Adjustment Reason Codes and Remittance Remark Codes may be found on the Division of Medical Services' website, www.dss.mo.gov/dms, and clicking on the link "HIPAA related code lists".

The date on the RA is the date the final processing cycle runs. Reimbursement will be made through a mailed check or a direct bank deposit approximately two weeks after the cycle run date. (See Claims Processing Schedule at the end of Section 1.)

The RA is grouped first by paid claims and then by denied claims. Claims in each category are listed alphabetically by the patient's last name. If the patient's name and/or Departmental Client Number (DCN) are **not** on file, only the first two letters of the last name and first letter of the first name appear.

Each claim entered into the claims processing system is assigned a 13-digit Internal Control Number (ICN) assigned for identification purposes. The first two digits of an ICN indicate the type of claim.

15 – Paper claim
18 – Paper Medicare Part B Crossover
40 – Electronic Medicare Crossover
49 – Internet claim

70 – Individual Credit to an Adjustment
50 – Individual Adjustment Request
75 – Credit Mass Adjustment
55 – Mass Adjustment

The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date the claim was entered into the system. In the Julian system, the days are numbered consecutively from "001" (January 01) to "365" or "366" in a leap year (December 31). The last digits of an ICN are for internal processing.

The ICN 1504277315020 is read as a paper medical claim entered in the processing system on October 04, 2004.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the printed RA pages.

When a claim denies for other insurance, the commercial carrier information is shown. Up to two policies can be shown.

PRINTABLE REMITTANCE ADVICE

The Printable Internet Remittance Advice is accessed at www.emomed.com. A provider must be enrolled with emomed.com in order to access the website and the printable RA. To sign-up for emomed.com and the on-line Remittance Advice option, visit the Missouri Medicaid website, www.dss.mo.gov/dms, and select the Provider Information "internet access" link.

On the Printable Remittance Advice page, click on the RA date you wish to view, print or save and follow your Internet browser's instructions. The RA is in the PDF file format. Your browser will open the file directly if you have Adobe Acrobat Reader installed on your computer. If you do not have this program, go to http://www.adobe.com/products/acrobat/readsetp2.html to download it to your computer.

RAs are available automatically following each financial cycle. Each RA remains available for a total of 62 days. The oldest RA drops off as the newest becomes available. Therefore, providers are encouraged to save each RA to their computer system for future reference and use.

Note: When printing an RA, it is set to page break after 70 lines per page.

If a provider did not save an RA to his/her computer and wants access to an RA that is no longer available, the provider can request the RA through the "Aged RA Request" link on the emomed.com home page.

In general, the Printable Remittance Advice is displayed as follows.

Field	Description
RECIPIENT NAME	The recipient's last name and first name. NOTE: If the recipient's name and identification number are not on file, only the first two letters of the last name and first letter of the first name appear.
MEDICAID ID	The recipient's 8-digit Medicaid identification number.
ICN	The 13-digit number assigned to the claim for identification purposes.
SERVICE DATES FROM	The initial date of service in MMDDYY format for the claim.
SERVICE DATES TO	The final date of service in MMDDYY format for the claim.
PAT ACCT	The provider's own patient account name or number.
CLAIM: ST	This field reflects the status of the claim. Values are: 1 = Processed as Primary, 3 = Processed as Tertiary, 4 = Denied, 22 = Reversal of Previous Payment
TOT BILLED	The total claim amount submitted.
TOT PAID	The total amount Medicaid paid on the claim.
TOT OTHER	The combined totals for patient liability (surplus), recipient copay, and spenddown total withheld.
LN	The line number of the billed service.
SERVICE DATES	The date of service(s) for the specific detail line.
REV/PROC/NDC	The submitted procedure code, NDC, or revenue code for the specific detail line. Note: The revenue code will only appear in this field if a procedure code is not present.
MOD	The submitted modifier(s) for the specific detail line.
REV CODE	The submitted revenue code for the specific detail line. Note: The revenue code only appears in this field if a procedure code has also been submitted.
QTY	The units of service submitted.
BILLED AMOUNT	The submitted billed amount for the specific detail line.
ALLOWED AMOUNT	The Medicaid maximum allowed amount for the procedure.
PAID AMOUNT	The amount Medicaid paid on the claim.
PERF PROV	The Medicaid ID number for the performing provider submitted at the detail.

Field	Description
SUBMITTER LN ITM CNTL	The submitted line item control number.
GROUP CODE	The Claim Adjustment Group Code is a code identifying the general category of payment adjustment. Values are: CO = Contractual Obligation CR = Correction and Reversals OA = Other Adjustment PI = Payer Initiated Reductions PR = Patient Responsibility
RSN	The Claim Adjustment Reason Code is the code identifying the detailed reason the adjustment was made.
AMT	The dollar amount adjusted for the corresponding reason code.
QTY	The adjustment to the submitted units of service. This field will not be printed if the value is zero.
REMARK CODES	The Code List Qualifier Code and the Health Care Remark Code (Remittance Advice Remark Codes). The Code List Qualifier Code is a code identifying a specific industry code list. Values are: HE = Claim Payment Remark Code RX = National Council for Prescription Drug Programs Reject/Payment Codes. The Health Care Remark Codes (Remittance Advice Remark Codes) are codes used to convey information about remittance processing or to provide a supplemental explanation for an adjustment already described by a Claim Adjustment Reason Code.
CATEGORY TOTALS	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, etc.) has separate totals for number of claims, billed amount, allowed amount, and paid amount.

HCY SCREENINGS

Developmental/Mental Health Partial Screens are billable by a psychologist, LCSW or LPC with the new codes. These screening codes do not use the AH, AJ, UD, or U8 modifiers. Instead the codes must have a 59 modifier and if the child is referred on for further care a UC modifier. The diagnosis code V202 is the only valid diagnosis code for a partial HCY screening.

99429 59	$15.00
99429 59 UC	$15.00

Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

MODIFIERS

Effective for dates of service November 01, 2003 and after claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

AH – Psychologist
AJ – Licensed Clinical Social Worker
UD – Licensed Professional Counselor
U8 – in home (12) or private school (99)
(The U8 modifier is not appropriate when billing 90853 regardless of POS)

Effective for date of service August 21, 2005 and after, a new modifier has been added for use to track services provided to patients identified as catastrophe/disaster victims in any part of the country. This new modifier is used in addition to any other required modifiers. There is no additional reimbursement associated with use of this modifier.

CR – Catastrophe/Disaster Related

FREQUENTLY USED PLACE OF SERVICE CODES (POS)

04 – Homeless Shelter	11 – office
12 – Home	14 – Group Home
21 – Inpatient Hospital	22 – Outpatient Hospital
33 – Custodial Care Facility	50 – FQHC
51 – Inpatient Psychiatric Facility	56 – Psychiatric Residential Treatment
61 – Comprehensive Inpatient Rehabilitation Facility	
72 – Rural Health Clinic	99 – Private School

Refer to the Special HIPAA bulletin dated September 30, 2003 or the CMS Web site for complete list of POS codes and additional description information.

TIME-BASED SERVICE LIMITATIONS

A therapy procedure code representing a measure of time as defined in the CPT is covered for one (1) unit per day. The provider must choose the appropriate time measure to represent the service furnished.

A unit of service, which represents 20-30 minutes, must include at least 20 minutes **face-to-face** with the client. When less than 30 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Appointments must be scheduled in 30-minute increments to bill Medicaid for one (1) half-hour session of service. Appointments scheduled less than 30 minutes are deemed to be less than 20 minutes face-to-face and are not covered.

A unit of service, which represents 45-50 minutes, must include at least 45 minutes **face-to-face** with the client. When less than 50 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Appointments must be scheduled in 50-minute increments to bill Medicaid for a 45-50 minute session of service. Appointments scheduled less than 50 minutes are deemed to be less than 45 minutes face-to-face and are not covered.

Currently, the CPT definition for Assessment, Family Therapy with or without the patient present, and Group Therapy is not time limited; and DMS defines a unit of service as a half hour. (These therapies must be provided in full 30-minute units.)

Testing and Crisis Intervention are defined in the CPT as hour services and a full 60 minutes of services must be provided.

Travel time is not reimbursable and must not be included as part of the scheduled appointment time.

Providers may not bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour of 90804 and 45-50 minutes of 90806 is not covered on the same date of service.

Providers may not bill a combination of time measured psychotherapy codes with a code including a medical component. For example 90804 and 90805 are not covered on the same date of service.

Certain services include a medical component and are not billable by a psychologist, LCSW, or LPC. These codes are 90805, 90807, 90811, 90813, 90817, 90819, 90824, 90827, 90862, 90865, *and 90870*.

Certain services are not covered when provided by an LCSW or LPC and may not be billed for an adult or child in any setting. These codes are 96101, 96103, 96105, 96111, and 96116.

Psychology/counseling services are not billable by a psychiatrist, PCNS, psychologist, LCSW or LPC in a nursing home setting. **Psychiatrists and PCNS may provide pharmacologic management, procedure code 90862 in the nursing home setting.**

FAMILY THERAPY

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When Family Therapy without the patient present (90846) or Family Therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Providers may not bill for Family Therapy for each family member. This will be monitored by the Program Integrity Unit. Treatment of family members (adults) is not covered when provided by an LCSW or LPC. Family Therapy furnished by an LCSW or LPC must be directed exclusively to the treatment of the child. **Parental issues may not be billed and Family Therapy is only billable when defined in the Treatment Plan as necessary on behalf of the identified patient.**

A psychiatrist, PCNS, and psychologist may bill for services provided to an adult. When a family consists of a Medicaid/MC+ eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child's DCN.

Only one (1) Prior Authorization will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's DCN must be used for Prior Authorization and billing purposes. When a specific child is identified as the primary recipient of treatment, that child's DCN must be used for Prior Authorization and billing purposes. Providers should not request more than one (1) Family Therapy Prior Authorization per family.

A family may be biological, foster, adoptive or other family unit. A family is not a group and **providers may not submit a claim for each eligible person attending the same family therapy session. At least 75% of the session must have both child/children and parent(s) present.**

GROUP THERAPY

Group Therapy must consist of 3 but no more than 10 individuals who are not members of the same family. This applies to inpatient Group Therapy sessions also.

Group Therapy may not be billed on the same date of service as Family Therapy (90846 or 90847) unless the client is inpatient, in a residential treatment facility, or custodial care facility. *Services must be provided at the facility location.* Group Therapy in a group home is billed with POS 14. Group Therapy in a residential/custodial facility is billed with POS 33. Group Therapy in a shelter type setting is billed with POS 04.

PLACE OF SERVICE CODE

Effective for dates of service July 01, 2005 and after, the only valid setting for using place of service code 99 is a private school. (Head Start is not considered a private school.)

Place of service 99 cannot be used for therapy provided in a public setting. A public setting includes but is not limited to: a parked or moving vehicle, library, park, shopping center, restaurants, etc. Providers must use the appropriate place of service code for the setting in which services are rendered. If there is no place of service code that matches the setting, services may not be billed to Medicaid. Although there is a place of service 15 for mobile unit, Medicaid does not cover services provided in this setting.

Place of service 11 (office) is to be used for settings such as a Head Start. Centers for Medicare and Medicaid Services (CMS) has defined an office as a location where the health professional routinely provides services.

Place of service 04 (homeless shelter) should be used when services are provided in a setting such as a crisis center or Salvation Army housing. The CMS definition of a homeless shelter is a facility or location that provides temporary housing.

SCHOOL BASED SERVICES

When services are provided on public school grounds, the provider must enroll with a pay-to of the school district in which the school is located. A Missouri Medicaid provider number is required for each school district where services are being provided. The only appropriate place of service for a public school setting is 03 and must be used.

DIAGNOSIS CODES

The diagnosis code must be a valid ICD-9 diagnosis code and must be mental health related. This does not include mental retardation. The only valid code ranges for the psychology/counseling program are *295*-316, V11-V118, V154-V1542, V17-V170, V40-V401, V61-V619, V624, V628-V6289, V673, V710-V7102, and V79-V791. An appropriate 4th or 5th digit may be required for the diagnosis code to be valid.

DOCUMENTATION REQUIREMENTS

DIAGNOSTIC ASSESSMENT

A current Diagnostic Assessment a defined in CSR 70-98.015 from a Medicaid enrolled provider must be documented in the client's medical record. This assessment will assist in ensuring an appropriate level of care, identifying necessary services, developing a treatment plan and documenting the following:

- Statement of needs, goals, and treatment expectations from the individual requesting services; the family's perceptions when appropriate and available
- Presenting problem and referral source
- History of previous psychiatric and/or substance abuse treatment including number and type of admissions
- Current medications; medication allergies/adverse reactions
- Recent alcohol/drug use for at least the past 30 days; a substance abuse history including duration, patterns, and consequence of use
- Current psychiatric symptoms
- Family, social, legal, and vocational/educational status and functioning. Historical data is also required unless short-term crisis intervention or detoxification are the only services being provided
- Current use of resources and services from other agencies
- Personal and social resources and strengths, including availability of family, peer, and other natural supports
- Multi-axis diagnosis or diagnostic impression according to the current edition of the DSM or International Classification of Diseases, Ninth Revision (ICD-9). The ICD-9 code is required on the treatment plan for billing purposes.

PLAN OF TREATMENT

A current Plan of Treatment as defined in CSR 70-98.015 is required documentation as part of the client's medical record. A treatment plan must be developed based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the client's situation and reflects the need for psychology/counseling services. The Treatment Plan must be individualized to reflect the unique needs and goals of the client. The Treatment Plan must include but is not limited to the following:

- Measurable goals and outcomes
- How each goal/outcome will be accomplished
  - Services, supports, staff member responsible,
  - Actions required of the recipient, family, peers, etc.
- Involvement of family, when indicated
- Identification of and plan for coordinating with other agencies
- Referrals to other organizations for other needed services
- Identification of medications
- Projected time frame for completion of each goal/outcome
- Estimated completion/discharge date

TREATMENT UPDATE:

The Treatment Plan must be reviewed on a periodic basis to evaluate progress towards goals/outcomes and to update the plan. Each client will participate in the review of his/her treatment plan. The frequency of plan reviews is based on the level of care or other program rules. A crisis or significant event may require additional review and the treatment plan must be updated and changed as indicated. Each update must include the therapist's assessment of current symptoms and behaviors related to diagnosis, progress towards goals, justification of changed or new diagnosis, and response to other concurrent treatments such as family or group therapy and medications. Plans for continuing treatment and/or termination from therapy and aftercare must be expressed in each Treatment Plan update.

PROGRESS NOTES

Progress Notes as defined in CSR 70-98.015 must be written in narrative form, fully describe each session, and be kept in the patient's medical record for each date of service for which a claim is filed. A check-off list or pre-established form is not acceptable as sole documentation. Progress notes for Psychology/Counseling services must specify:

- First and last name of client
- Specific service rendered
- Date (month/day/year)
- Actual clock begin and end times (1:00 p.m. to 2:00 p.m.)
- Name of person who provided the service
- Setting
- Patient's report of recent symptoms and behaviors related to diagnosis and treatment plan goals
- Therapist's intervention for the visit and recipient's response
- Patient's progress towards goals in treatment plan
- FamilyTherapy - must identify each member of the family, first and last name, included in the session and
    - Description of immediate issue addressed
    - Identification of underlying roles, conflicts or patterns
    - Description of therapist intervention, patient response, and progress toward specific goal
- Group Therapy - must identify the number of group members present and
    - Description of immediate issue addressed
    - Identification of underlying roles, conflicts or patterns
    - Description of therapist intervention, patient's response, and progress towards goals

(FYI – These are generalized points of CSR 70-98.015. Providers should refer to this rule for a complete description of the documentation requirements.

Note: If **Individual Interactive Therapy** is provided, the documentation must include the need for this service and the type of equipment, devices, or other mechanism of equipment used. (This is specifically required per CSR 70-98.015).

If the service is for a child in the legal custody of the Children's Division (CD), a copy of the Treatment Plan must be provided to the CD.

These documentation requirements do not replace or negate documentation/reports required by CD for individuals in their care and custody. Providers are expected to comply with policies and procedures established by CD.

AFTERCARE PLAN

When care is completed, the aftercare plan must include, but is not limited to, the following:

- Dates (care) begin and end
- Frequency and duration of visits
- Target symptoms/behaviors addressed
- Interventions
- Progress achieved towards goals
- Final diagnosis
- Final recommendations including further services, providers, and activities to promote further recovery

For all medically necessary covered services, the stipulated documentation is an essential and integral part of the service. No service will be considered performed if documentation requirements are not met, and no reimbursement will be made.

Only the enrolled Missouri Medicaid provider can provide psychology/counseling services and be reimbursed. Missouri Medicaid does not cover services provided by someone other than the enrolled provider.

Services provided by an individual under the direction or supervision of the enrolled provider are not covered.

Medicaid providers must retain for six (6) years from the date of service, fiscal and medical records that coincide with and fully document services billed to Medicaid and must furnish or make records available for inspection or audit by the Department of Social Services or its representative upon request.

PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only counseling codes billable by an LCSW or LPC. The appropriate AJ or UD must be used for all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		$24.00	6	Assessment
90801	U8	$29.00	6	Assessment-home/private school (PS)
90802		$24.00	2	Assessment-interactive (intac)
90802	U8	$29.00	2	Assessment-interactive-home/PS
90804		$24.00	1	Individual 20-30 mins
90804	U8	$29.00	1	Individual 20-30 mins- home/PS
90806		$48.00	1	Individual 45-50 mins
90806	U8	$58.00	1	Individual 45-50 mins- home/PS
90810		$24.00	1	Intac Indiv 20-30 mins
90810	U8	$29.00	1	Intac Indiv 20-30 mins- home/PS
90812		$48.00	1	Intac Indiv 45-50 mins
90812	U8	$58.00	1	Intac Indiv 45-50 mins-home/PS
90816		$24.00	1	Indiv hosp 20-30 mins
90818		$48.00	1	Indiv hosp 45-50 mins
90823		$24.00	1	Intac Indiv Hosp 20-30 mins
90826		$48.00	1	Intac Indiv Hosp 45-50 mins
90846		$24.00	2	Family w/o Patient
90846	U8	$29.00	2	Family w/o Patient-home/PS
90847		$24.00	2	Family w/ Patient
90847	U8	$29.00	2	Family w/ Patient-home/PS
90853		$10.00	3	Group Therapy
S9484		$48.00	6	Crisis Intervention, hour
S9484	U8	$53.00	6	Crisis Intervention, hour-home/PS

PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only counseling codes billable by a Psychologist. The AH modifier must be used on all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		$30.00	6	Assessment
90801	U8	$35.00	6	Assessment-home/private school PS
90802		$30.00	2	Assessment-interactive (intac)
90802	U8	$35.00	2	Assessment-interactive-home/PS
90804		$30.00	1	Individual 20-30 mins
90804	U8	$35.00	1	Individual 20-30 mins- home/PS
90806		$60.00	1	Individual 45-50 mins
90806	U8	$70.00	1	Individual 45-50 mins- home/PS
90810		$30.00	1	Intac Indiv 20-30 mins
90810	U8	$35.00	1	Intac Indiv 20-30 mins- home/PS
90812		$60.00	1	Intac Indiv 45-50 mins
90812	U8	$70.00	1	Intac Indiv 45-50 mins-home/PS
90816		$30.00	1	Indiv hosp 20-30 mins
90818		$60.00	1	Indiv hosp 45-50 mins
90823		$30.00	1	Intac Indiv Hosp 20-30 mins
90826		$60.00	1	Intac Indiv Hosp 45-50 mins
90846		$30.00	2	Family w/o Patient
90846	U8	$35.00	2	Family w/o Patient-home/PS
90847		$30.00	2	Family w/ Patient
90847	U8	$35.00	2	Family w/ Patient-home/PS
90853		$12.50	3	Group Therapy
90880		$8.00	1	Hypnotherapy
90885		$24.00	1	Psych eval of records
96101		$60.00	4	Testing – admin by psychologist
96101	U8	$60.00	4	Testing – psychologist - home/PS
96103		$20.00	4	Testing – admin by computer
96103	U8	$20.00	4	Testing – admin by comp – home/PS
96105		$35.00	1	Assess of aphasia
96111		$35.00	1	Developmental testing, extended
96116		$35.00	1	Neurobehavior status exam
S9484		$60.00	6	Crisis Intervention, hour
S9484	U8	$65.00	6	Crisis Intervention, hour- home/PS

PSYCHIATRISTS, PSYCHIATRIC CLINICAL NURSES, FQHC, AND RHC

Procedure Code	Modifier	Medicaid Maximum Allowed	Maximum Quantity	Description
90801		$30.00	6	Psy dx interview
90801	U8	$35.00	6	Psy dx interview, home/private school PS
90802		$30.00	2	Intac psy dx interview
90802	U8	$35.00	2	Intac psy dx interview, home/PS
90804		$30.00	1	Psy tx, office, 20-30 min
90804	U8	$35.00	1	Psy tx, 20-30 min, home/PS
90805		$35.00	1	Psy tx, off, 20-30 min w/e&m
90805	U8	$40.00	1	Psy tx, 20-30 min w/e&m, home/PS
90806		$60.00	1	Psy tx, off, 45-50 min
90806	U8	$70.00	1	Psy tx, 45-50 min, home/PS
90807		$65.00	1	Psy tx, off, 45-50 min w/e&m
90807	U8	$75.00	1	Psy tx, 45-50 min w/e&m home/PS
90810		$30.00	1	Intac psy tx, off, 20-30 min
90810	U8	$35.00	1	Intac psy tx, 20-30 min, home/PS
90811		$35.00	1	Intac psy tx, 20-30 w/e&m
90811	U8	$40.00	1	Intac psy tx, 20-30, w/e&m, home/PS
90812		$60.00	1	Intac psy tx, off, 45-50 min
90812	U8	$70.00	1	Intac psy tx, 45-50 min home/PS
90813		$65.00	1	Intac psy tx, 45-50 min w/e&m
90813	U8	$75.00	1	Intac psy tx, 45-50 min w/e&m, home/PS
90816		$30.00	1	Psy tx, hosp, 20-30 min
90817		$35.00	1	Psy tx, hosp, 20-30 min w/e&m
90818		$60.00	1	Psy tx, hosp, 45-50 min
90819		$65.00	1	Psy tx, hosp, 45-50 min w/e&m
90823		$30.00	1	Intac psy tx, hosp, 20-30 min
90824		$35.00	1	Intac psy tx, hosp 20-30 w/e&m
90826		$60.00	1	Intac psy tx, hosp, 45-50 min
90827		$65.00	1	Intac psy tx, hosp, 45-50 w/e&m
90846		$30.00	2	Family psy tx w/o patient
90846	U8	$35.00	2	Family psy tx w/o patient, home/PS
90847		$30.00	2	Family psy tx w/patient
90847	U8	$35.00	2	Family psy tx w/patient, home/PS
90853		$12.50	3	Group psychotherapy
90862		$12.50	1	Medication management
90865		$25.00	1	Narcosynthesis
90870		$30.00	1	Electroconvulsive therapy

Procedure Code	Modifier	Medicaid Maximum Allowed	Maximum Quantity	Description
90880		$8.00	1	Hypnotherapy
90885		$24.00	1	Psy evaluation of records
96101		$60.00	4	Testing – admin by physician
96101	U8	$60.00	4	Testing – admin by phys – home/PS
96103		$20.00	4	Testing – admin by computer
96103	U8	$20.00	4	Testing – admin by computer – home/PS
96105		$35.00	1	Assessment of aphasia
96111		$35.00	1	Developmental test, extend
96116		$35.00	1	Neurobehavior status exam
S9484		$60.00	6	Crisis intervention, per hour
S9484	U8	$65.00	6	Crisis intervention, per hour home/PS

The U8 Modifier is the only appropriate modifier and must be used when submitting claims for place of service 12 (home) or 99 (private school – PS) as indicated.

Procedure Codes

Effective for dates of service January 01, 2006 and after, procedure codes 90871, 96100, and 96115 are no longer valid codes for billing. These codes are valid for services provided December 31, 2005 and before.

Effective for dates of service January 01, 2006 and after, providers must use the new, appropriate procedure code when billing for testing, 96101 or 96103.

Psychological Testing may NOT be performed by an LCSW or LPC.

Psychological Testing administered by a technician (96102) is NOT a covered service.

Neuropsychological Testing (96118, 96119, and 96120) are NOT covered services.

PRIOR AUTHORIZATION

ADULTS

Psychologist, Psychiatrist, PCNS, RHC, FQHC

The Psychology/Counseling bulletin, dated October 01, 2004, outlined a new Prior Authorization (PA) process. Prior Authorization approves the medical necessity of the requested service and does not guarantee payment. The patient must meet eligibility requirements and the provider must be enrolled and eligible to bill the services.

Effective for dates of service November 01, 2004, and after, many Psychological services provided to adults (21 years of age or older) must be prior authorized when performed by a Psychiatrist, Psychologist, Psychiatric Clinical Nurse Specialist (PCNS), Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC).

Effective for dates of service May 01, 2005 and after Individual Interactive Therapy for adults is not allowed under the four (4) hours of non-prior authorized services. All Individual Interactive Therapy must be prior authorized.

Adult services provided by LCSWs and LPCs are not covered by Missouri Medicaid, except in an RHC or FQHC setting.

Family Therapy Without the Patient Present requires prior authorization for adults regardless of age.

CHILDREN

In subsequent phases, the Division of Medical Services (DMS) will implement new Prior Authorization measures for children for most Psychology/Counseling services.

Effective for dates of service May 01, 2005 and after, the PA process was implemented for children, 0 through 20 years of age, who are not in state custody or residing in a residential treatment facility.

The PA process for children in state custody or residing in a residential treatment facility will be implemented at a later date. Providers will be notified via bulletins regarding the effective dates for these groups of children.

The requirement for Prior Authorization will include services provided by a Psychiatrist, Psychologist, PCNS, Provisionally Licensed Clinical Social Worker

(PLCSW), Licensed Clinical Social Worker (LCSW), Provisionally Licensed Professional Counselor (PLPC), Licensed Professional Counselor (LPC), RHC, or FQHC.

ADULTS AND CHILDREN

Codes Requiring PA – Psychologist, Psychiatrist, PCNS, RHC, and FQHC

Assessment – Interactive 90802 (30 minute session)
Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)
Individual Therapy 90806 / 90812 (45 – 50 minute session)
Maximum of 1 unit, either 30 minute or 45-50 minute session per day;
Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month

Family Therapy 90846 / 90847 (30 minute session)
Maximum of 2 units per procedure per day;
Maximum of 10 units per month

Group Therapy 90853 (30 minute session)
Maximum of 3 units per day;
Maximum of 15 units per month

Hypnotherapy 90880 (no time frame noted)

Aphasia Assessment 96105 (60 minute session)

Developmental testing 96111 (60 minute session)

Neurobehavioral testing *96116* (60 minute session)

Effective for dates of service 07-01-05 and after, 90899 unlisted psychiatric services or procedures will no longer be a payable code.

The AH modifier must be included when billing claims for Psychologists.

Codes Not Requiring PA – Psychologist, Psychiatrist, PCNS, RHC and FQHC

Assessment – Insight	90801 (30 minute session) Maximum of 6 units per rolling year
Testing	96101 / 96103 (60 minute session) Maximum of 4 units per rolling year
Individual Inpatient	90816 / 90823 (20 – 30 minute session)
Individual Inpatient	90818 / 90826 (45 – 50 minute session)
Evaluation Inpatient Records	90885 (no time frame noted)
Evaluation and Management codes	
Crisis Intervention	**S9484 (60 minute session)** **Maximum of 6 units per rolling year.**

Regardless of Prior Authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

CHILDREN

Codes Requiring PA – PLCSW, LCSW, PLPC, LPC

Assessment – Interactive 90802 (30 minute session)
Maximum of 2 units per rolling year

Individual Therapy 90804 / 90810 (20 – 30 minute session)
Individual Therapy 90806 / 90812 (45 – 50 minute session)
Maximum of 1 unit, either 30 minute or 45-50 minute session per day;
Maximum of 5 units, any combination of 30 minute or 45-50 minute sessions per month

Family Therapy 90846 / 90847 (30 minute session)
Maximum of 2 units per procedure per day;
Maximum of 10 units per month

Group Therapy 90853 (30 minute session)
Maximum of 3 units per day;
Maximum of 15 units per month

Codes Not Requiring PA – PLCSW, LCSW, PLPC, LPC

Assessment – Insight 90801 (30 minute session)
Maximum of 6 units per rolling year

Individual Inpatient 90816 / 90823 (20 – 30 minute session)

Individual Inpatient 90818 / 90826 (45 – 50 minute session)

Crisis Intervention S9484 (60 minute session)
Maximum of 6 units per rolling year.

Regardless of Prior Authorization, providers are required to adhere to the maximum daily and monthly unit limitations and all other program restrictions. Units over the daily and monthly limits will no longer be reimbursed.

ALL PROVIDERS

Effective for dates of service December 01, 2005 and after, Testing and Diagnostic Assessment (Insight-90801) have been removed for the Prior Authorization process for most clients.

Diagnostic Assessment (Interactive-90802) continues to require Prior Authorization regardless of the age of the client.

Testing is still limited to independent Psychiatrists and Psychologists or those providing services through an RHC or FQHC. Missouri Medicaid does not reimburse for testing when performed by an LPC, PLPC, LCSW or PLCSW regardless of the setting.

All services for all children under the age of three (3), including those in state custody and residential care facilities, continue to require Prior Authorization. This includes Testing and Assessment services.

DEFINITIONS

Crisis Intervention

The definition of crisis intervention is: "A face-to-face contact to diffuse a situation of immediate crisis. The situation must be of significant severity to pose a threat to the patient's well being or is a danger to him/herself or others". Crisis intervention services cannot be scheduled nor can they be prior authorized.

Individual Interactive Therapy

Individual Interactive Therapy is typically furnished to children and involves the use of physical aids and non-verbal communication to overcome barriers to interaction between the clinician and the patient who has not yet developed, or has lost, either the expressive language communications skills to explain symptoms and response to treatment, or the receptive communication skills to understand the clinician if ordinary adult language were used for communication.

Family Therapy

Family therapy is the treatment of the members of a family together, parent(s) and child(ren) rather than an individual "patient". The family unit is viewed as a social system that affects all its members. A parent must be present to be considered Family Therapy. (Refer to Section 4.3)

Group Therapy

Group Therapy uses group dynamics and peer interactions to increase understanding and improve social skills. Group therapy is a medically necessary, time-limited, goal-specific, face-to-face interaction based upon planned interventions documented in the Treatment Plan. Groups are limited to a minimum of three (3) but no more than ten (10) patients.

(Providers should refer to the April 13, 2005 bulletin for more detailed information regarding these definitions.)

GUIDELINES - Adults

A Prior Authorization (PA) process for psychological services for adults was implemented November 01, 2004. In order to facilitate changes in Prior Authorization policy, all PAs for adult psychological services were closed effective December 31, 2005. New guidelines for the adult PA process were implemented effective January 01, 2006.

Independent LCSWs and LPCs may not see adults and should not request prior authorization for Psychology/Counseling services for clients 21 year of age or older.

LCSWs and LPCs who are members of an FQHC or RHC may provide adult services as part of the clinic. These services will require prior authorization but the request is made using the facility provider number.

The first four (4) hours of psychotherapy services for adults do not require prior authorization. These four (4) hours are intended to allow the provider opportunity to assess the patient's need for ongoing treatment. The first four (4) hours are per patient, per provider, per rolling year. These four (4) non-Prior Authorized hours do not include Family Therapy without the patient present or Individual Interactive Therapy. All hours of these therapies must be Prior Authorized before rendering services.

Providers who have rendered therapy services to a recipient within the past 12 months will be considered as having used their four (4) non-prior authorized hours.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, Prior Authorization must be obtained. This Prior Authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial PA and any services requested after this will be considered continued treatment.

Psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. PA approval is based on the DSM IV-TR diagnosis code. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

Up to ten (10) hours of Individual or Family Therapy or a combination of both will be authorized initially for a covered diagnosis of Adjustment Disorder, V-codes, or NOS codes. The intent is to limit any PA to no more than ten (10) hours of Individual or Family Therapy or a combination of the two for these diagnosis codes for any recipient regardless of the provider.

Up to twenty (20) hours will be authorized initially for Individual and Family Therapy or a combination of both for all other covered diagnosis codes. The intent is to limit the first PA to no more than twenty (20) hours of Individual or Family Therapy in any combination for any recipient regardless of provider.

The authorized hours may be divided between Individual and Family Therapy based upon provider request, recipient need and documentation in the treatment plan. This change was effective for dates of service January 01, 2006 and after.

Based upon provider request up to ten (10) hours of Group Therapy will be authorized for a covered diagnosis of Adjustment Disorder, V-codes, or NOS codes.

Based upon provider request up to twenty (20) hours of Group Therapy will be authorized for all other covered diagnosis codes.

Group Therapy may be requested in addition to the Individual and Family request outlined above. The intent is to limit the first PA to no more than twenty (20) hours of group therapy for any recipient regardless of provider.

An additional ten (10) hours of Individual, Family or Group Therapy or any combination may be requested based upon documentation of patient need. PAs for continued treatment (authorizations beyond the initial approved hours) will be based upon review of clinical documentation to include:

- Psychological Services Request for Prior Authorization form
- Current Diagnostic Assessment
- Current/Updated Treatment Plan
- Three (3) Progress Notes reflective of therapy type requested (i.e. requests for additional Family Therapy should include Progress Notes from the three most recent Family Therapy sessions attended by the patient)

PAs for continued treatment will **not** be issued for diagnosis codes including Adjustment Disorder, V codes, or NOS codes.

All documentation submitted must meet the requirements as stated in 13 CSR 70-98-015. Requests submitted with non-compliant documentation as outlined above will result in denial of the request.

The DMS recognizes there are rare instances were Psychological services may be authorized beyond the limits outlined above. For those persons requiring more than the thirty (30) hours of Individual, Family or Group Therapy per year, as discussed above, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

REQUESTING PRIOR AUTHORIZATION

Providers may deliver four (4) hours of Psychological Services without Prior Authorization to a recipient they have not provided treatment to within the last rolling year. The four (4) hours are intended to assist a provider seeing a recipient for the first time in making the transition to PA should more than four (4) hours be required for treatment. Providers who have been paid for services in excess of four (4) hours for a recipient in the last year will not receive four (4) non-prior authorized hours for that recipient.

Family Therapy without the patient present, Individual Interactive Therapy and **all** Psychological Services for recipients age 0 through 2 years are not included in the four (4) non-prior authorized hours and continue to require PA.

The claims for the four (4) non-prior authorized hours should be submitted and payment established prior to submitting claims for any prior authorized hours/services.

If services are required beyond the initial four (4) non-prior authorized hours, the provider must request a Prior Authorization. To request an initial *PA* you or a staff member may call (866) 771-3350. Although not mandatory, you should complete the Psychological Services Request for Prior Authorization form as the information on this form will be required to complete the request for services. Please see the attachment to the May 27, 2005 bulletin, Volume 27, Number 20 for a copy of the PA request form. Telephoned requests will receive an approval or denial at the time of the call. (**If additional information is needed, the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.**

To request continuing services beyond the initial authorization, the Psychological Services Request for Prior Authorization form must be completed and submitted along with the (1) current Treatment Plan, (2) current diagnostic assessment and

(3) copies of the last three (3) Progress Notes reflecting the therapy type being requested.

This documentation may be faxed to: **(573) 635-6516**

or mailed to: Division of Medical Services
PO Box 4800
Jefferson City, MO 65102.

Before requesting additional hours, 75% of the current authorized hours must be used. The PA approves the delivery of the requested services only and does not guarantee payment. The PA must be obtained prior to delivery of services. The recipient must meet eligibility requirements on the date the service is provided and the provider must be enrolled and eligible to bill for the services.

All Family Therapy without the patient present and Individual Interactive Therapy will require the PA Form, current Diagnostic Assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the client DCN, type of therapy to be closed and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

When a client changes providers any available units will be transferred from the closed PA to the new providers approved PA. The new provider will not receive an additional 10 or 20 hours for therapy. The intent is to limit therapy services for any recipient regardless of provider. However, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

A client may have an open PA with one provider for Individual Therapy and/or Family Therapy and a second PA open with the same or different provider for Group Therapy.

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

Most Prior Authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request prior authorization using the individual (49) provider number. However, authorization for services being rendered by a member of an FQHC must be requested by using the FQHC (50) provider number. Services being rendered by a member of an RHC must request Prior Authorization using the RHC (59) provider number.

Prior Authorization is required even when there is coverage through a third party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered third party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior Authorization is required for clients residing in a nursing home but the psychology/counseling services may not be provided at the nursing home. **Psychiatrists and PCNS may provide pharmacologic management, procedure code 90862, in the nursing home setting.**

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior Authorization Exceptions

In-patient hospital stays

Crisis intervention

Testing

Assessment

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse.

GUIDELINES – Children

The Division of Medical Services (DMS) has made PA requirement changes for Psychological Services for children and will be implementing additional changes for children. Previous policy, new policy changes, and planned changes are outlined below.

Effective November 01, 2004, Individual Therapy, Family Therapy with the patient present, and Group Therapy required Prior Authorization for children under the age of three (3) when performed by a Psychiatrist, Psychologist, and Psychiatric Clinical Nurse Specialist.

Effective November 01, 2004, Family Therapy without the patient present requires Prior Authorization when provided by a Psychiatrist, Psychologist, Psychiatric Clinical Nurse Specialist, regardless of the **age of the client**.

Family Therapy without the patient present, regardless of the age of the child, has always required Prior Authorization when provided by an LCSW, LPC, PLCSW, PLPC, RHC, or FQHC. This policy remains in effect.

Prior Authorization has always been required for Individual Therapy, Family Therapy with the patient present, and Group Therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC.

When requesting Prior Authorization Psychological services will be covered if they are determined medically necessary when using the DSM IV-TR diagnostic criteria. However, the diagnosis code on a submitted claim must be the appropriate ICD-9 code.

Testing services are not covered when provided by a PLCSW, LCSW. PLPC, or LPC regardless of the age of the client.

All services for children under the age of three (3) and Family Therapy without the patient present require the PA Form, current Diagnostic Assessment, current Treatment Plan, and the last three (3) Progress Notes be mailed or faxed.

An authorization number will be provided. Services that require submission of the PA Form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Do not request overlapping dates from a previous PA; overlapping dates will cause the new PA request to deny.

If the client is changing providers, the provider listed on the current PA must end that PA before the new provider can be issued a PA. If the current provider refuses to close the PA, the new provider must submit a signed release from the client, requesting a change in provider, in order to close the current PA. The signed release must include the client's DCN, the type of therapy to be closed, and the name of the therapist whose authorization is to be closed.

If a provider needs to change a PA, the provider may call or fax in the information to request a change. The client's name, DCN, type of therapy, what the current PA says, and the requested change must be indicated.

Most Prior Authorizations will be requested using the individual (49) provider number. Private non-FQHC clinics/groups with a provider number beginning 50 must request Prior Authorization using the individual (49) provider number. Authorization for services being rendered by a member of an FQHC (Federally Qualified Health Care) must be requested by using the FQHC (50) provider number and the performing provider name. Services being rendered by a member of an RHC (Rural Health Clinic) must request prior authorization using the RHC (59) provider number.

Prior Authorization is required even when there is coverage through a third-party insurance (i.e. Blue Cross/Blue Shield; Prudential). Medicare is not considered a third-party insurance; however, if there is no PA and Medicare does not cover the service, Medicaid cannot pay.

Prior Authorization has always been required for Individual Therapy, Family Therapy with the patient present, and Group Therapy for children under the age of three (3) when services are provided by an LCSW, LPC, PLCSW, PLPC, RHC or FQHC. This policy remains in effect.

Prior Authorization is required for clients residing in a nursing home but the Psychology/Counseling services may not be provided at the nursing home. **Psychiatrists and PCNS may provide pharmacologic management, 90862, in the nursing home setting.**

Providers may only bill for services they personally provide. Medicaid does not cover services provided by someone other than the enrolled provider. Services provided by an individual under the direction or supervision of an enrolled provider are not covered.

Prior authorization is required for Psychological services provided on public school district grounds when billing to Medicaid. The provider must have a separate Medicaid provider number with a pay-to of the school district.

Prior Authorization Exceptions

Inpatient hospital stays

Crisis intervention

Testing

Assessment

Procedure codes with a medical evaluation and management service component

Pharmacologic management

Narcosynthesis

Electroconvulsive Therapy

Services covered and reimbursed by Medicare; if Medicare denies services a PA would be required for Medicaid to reimburse.

Effective for dates of service December 01, 2005 and after, Testing and Diagnostic Assessment (Insight-90801) have been removed for the Prior Authorization process for most clients.

Diagnostic Assessment (Interactive-90802) continues to require Prior Authorization regardless of the age of the client.

All services for all children under the age of three (3), including those in state custody and residential care facilities, continue to require Prior Authorization. This includes Testing and Assessment services.

State Custody Medicaid Eligibility (ME) Codes

At this time ME codes 07, 08, 29, 30, 35, 36, 37, 50, 51, 52, 53, 54, 56, 57, 63, 64, 66, 86, 69, 70, are exempt from Prior Authorization requirements due to the child being in state custody. When verifying eligibility, if the ME code is **not** one of these, regardless of other source information, you **must** request Prior Authorization.

Prior Authorization Policy for Children 0 through 20

Effective May 01, 2005, the Division of Medical Services implemented a prior authorization process for all children birth (0) through 20 who are not in state custody or residing in a residential treatment facility. Except for those situations previously indicated, Prior Authorization requirements for children in state custody or in a residential facility will be implemented at a later date. Future Psychotherapy bulletins will address enrollment of these additional populations.

The PA process includes services provided by a Psychiatrist, Psychologist, PCNS, PLCSW, LCSW, PLPC, LPC, RHC, and FQHC.

The first four (4) hours of Psychological services for most children and services do not require Prior Authorization. These four (4) hours are intended to assist a provider seeing a patient for the first time make the transition to PA should more than four (4) hours be required for treatment. These four (4) hours may consist of Individual Therapy, Group Therapy or Family Therapy. The first four (4) hours is per recipient, per provider, per rolling year. Providers who have been paid for services in excess of four (4) hours for a patient in the last year will not receive four (4) non-Prior Authorized hours for that client.

This does not apply if providing services to children under the age of 3, Individual Interactive Therapy, or Family Therapy without the patient present. All hours for these services must be prior authorized.

The claims for the four (4) non-prior authorized hours should be submitted and payment established prior to submitting claims for any prior authorized hours/services.

After the initial 4 hours, when it is determined that ongoing services are medically necessary, Prior Authorization must be obtained. This Prior Authorization must be requested before rendering additional services. In order not to interrupt services it would be best to request authorization before all 4 hours are used. The first PA request will be the initial authorization and any services requested after this will be considered continued treatment. Except for those situations indicated above the preferred method of therapy may be requested by calling the Psychological Services Prior Authorization telephone number.

You or a staff member may place the call but the Psychological Services Request for Prior Authorization (PA) Form, although not mandatory, should be completed as the information on this form will be required to complete the request for services. Telephoned requests will receive an approval or denial at the time of the call. If additional information is needed the caller will be instructed to fax or mail the PA form and required documentation. This PA request will not be approved during the phone call.

Prior authorization of Psychology/Counseling services for children is based on the age of the child and the type of therapy requested. Based on these limitations the first request for PA can include Individual, Family, and Group Therapy.

Assessment and Testing for a child under the age of 3 must be prior authorized and providers must submit clinical justification for providing these services. Prior Authorization does not allow the provider to exceed the unit limitations for these services.

To request continuing services after the initial authorization, the Psychological Services Request for Prior Authorization Form must be completed and submitted along with the current Treatment Plan, current Diagnostic Assessment and copies of the last three (3) Progress Notes. If the services being requested are court ordered, a copy of the court order must also be attached. Before requesting additional hours, 75% of the current authorized hours must be used.

Approval will be based on the DSM IV-TR diagnosis code. Up to ten (10) hours of Individual Therapy will be allowed for a diagnosis of Adjustment Disorder, V-codes, or NOS codes. Up to twenty (20) hours will be allowed for all other covered diagnosis codes. Family and Group Therapy will be approved for up to 10 hours for all covered mental health diagnoses. The authorized number of hours is based on the primary diagnosis and your documentation must support the diagnosis code.

Providers will not receive a disposition letter when services are authorized or denied via a phone call. An authorization number will be provided. Services that require submission of the PA form and attachments will receive a disposition letter after review. When PA requests are denied partially or in full, the client will receive a letter outlining the reason for denial and their appeal rights. **Do not give clients the provider Prior Authorization Request telephone number or fax number. Their contact information will be listed in their denial letter.**

Children are best treated within the environment in which they live. Clinical evidence suggests family intervention is superior to individual therapy in treating children with many psychological disorders. Therefore, treatment should support the child within the family whenever possible. Clinical evidence also suggests treatment must be based upon age and cognitive development of the child. Best Practice approaches should insure the coordination of care when multiple providers are involved with the same child/family.

Group therapy uses group dynamics and peer interactions to increase understanding and improve social skills.

Multiple therapies are the treatment of the individual with more than one therapy such as Individual and Family, simultaneously within the same authorization

period. The treatment plan must document the medical need for more than one therapy. There is no procedure code that specifies multiple therapies are being requested.

When requesting prior authorization for multiple therapies the Prior Authorization Request Form must be completed and faxed or mailed, along with the requested documentation, to DMS. The PA request needs to indicate all types of therapy being requested.

If a child's age changes during the prior authorization period, the prior authorization will continue as authorized. However, if the child turns 21 during the authorization period, the policy on age restriction for certain providers will apply. LPCs and LCSWs who are restricted to seeing children under the age of 21 will not be paid for services performed on or after the date the child reaches the age of 21 even if prior authorized.

Prior Authorization by Age Group

Psychology/counseling services for children under the age of 3, Family Therapy without the patient present and Individual Interactive Therapy will not be allowed under the 4 hours of non-prior authorized service. The preferred method of treatment is indicated first and if no documentation is required a telephone call may be made to request Prior Authorization. Services other than the preferred method and multiple therapies will require the PA Form and documentation be submitted via fax or mail.

Children Birth through 2

- Family Therapy authorized initially with documentation and review
- Individual Therapy will not be authorized
- Group Therapy will not be authorized

Children 3 through 4

- Family Therapy authorized initially without submitting documentation
- Individual Therapy will not be authorized with the exception of Interactive Therapy with documentation and review. Your documentation must support the reason why Individual Interactive Therapy is being provided
- Group Therapy will not be authorized

Children 5 through 12

- Family Therapy authorized initially without submitting documentation
- Group Therapy authorized initially with documentation and review
- Individual Therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 13 through 17

- Individual Therapy authorized initially without submitting documentation
- Family Therapy authorized initially without submitting documentation
- Group Therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Children 18 through 20

- Individual Therapy authorized initially without submitting documentation
- Family Therapy authorized initially with documentation and review
- Group Therapy authorized initially with documentation and review
- Multiple therapies authorized initially with documentation and review

Prior authorization requests may be made by calling: **(866) 771-3350**
OR submitting the PA form and required documentation to:

Mail: Division of Medical Services
PO Box 4800
Jefferson City, MO 65102
Fax: (573) 635-6516

Prior Authorization Tips

Children under the age of 3 always require a PA form and documentation. Testing and Assessment will also require clinical justification.

Call for approval on an initial Prior Authorization when the service does not require documentation.

If requesting Prior Authorization for multiple therapies fax or mail the PA form along with all required documentation even though it may be the initial request. When a PA request has been faxed or mailed allow sufficient time for the request to be reviewed. Do not send duplicate requests; expect at least five (5) days for a reply. You may call any/either of the following numbers to check on the status of a PA request:

Provider Communications	**(573) 751-2896**
Provider Education	**(573) 751-6683**

When faxing PA requests only send one (1) at a time. Multiple requests on the same fax must be handled differently and result in additional delay in response. Don't fax questions to the Psych Help Desk-send through Ask DMS e-mail.

Review the documentation requirements to insure all aspects have been included, are easily identified, and that appropriate documentation is being submitted with your prior authorization request.

Documentation is required for all services for children under 3, multiple therapies, continuing therapy, and non-preferred therapy. The required documentation is the current Diagnostic Assessment, current Treatment Plan, and the last 3 Progress Notes. If the Psychological services being requested are court ordered, a copy of the court order must also be attached to the documentation.

If a child's age changes during the authorization period the Prior Authorization will continue as authorized. **BUT** if the child turns 21 during the authorization period the policy for age restrictions will still apply even when services are prior authorized.

Prior Authorization requests will not be backdated. Allow sufficient time for submission and review of the PA and documentation. This includes enough time to resubmit the PA and documentation in the event the first submission is denied.

Daily and monthly limitations still apply even though an authorization has been approved.

SECTION 6
ADJUSTMENTS

Providers who are paid incorrectly for a claim should use the paper *Individual Adjustment Request* form to request an adjustment. Providers may also submit an individual adjustment via the Infocrossing Internet service, www.emomed.com, by using the claim frequency type option 7 for a replacement or option 8 for a void. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the necessary changes, listing each change separately. Field 15 of the form may be used to provide additional information. **Only one claim can be processed per *Individual Adjustment Request* form as each adjustment request can only address one particular claim.** A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

When using the Infocrossing Internet service to replace a paid claim using claim frequency type option 7, each line of the original paid claim must be re-entered even though a certain line or lines may not require an adjustment. A reprocessed Internet claim will have an ICN that begins with a “49”. Claim frequency type 8 is to be used only to void a previously paid claim and the payment is to be recouped. Claims voided through the Internet will appear on the next remittance advice with an ICN beginning with a “70”.

Providers submitting adjustment requests for changes in type of service codes or procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

If an adjustment filed on paper does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and any attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing. Adjustments for claim credits submitted via the Internet get a confirmation back the next day after submission to confirm the acceptance and indicate the status of the adjustment. If the Internal Control Number (ICN) on the credit adjustment is not valid, the confirmation file indicates such. If no confirmation is received, the provider should resubmit the claim credit.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Request* forms are to be submitted to the address shown on the form.

A sample Individual Adjustment Request is shown on the following page.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID

INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT ☑ OVERPAYMENT

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:
1. Claim Copy
2. Remittance Advice Copy

FORWARD ORIGINAL TO:
ATTENTION: ADJUSTMENT UNIT
DIVISION OF MEDICAL SERVICES
P O BOX 6500
JEFFERSON CITY MO 65102

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

3. INTERNAL CONTROL NUMBER 1604274009019	6. RECIPIENT NAME Nelson, Harry
4. RECIPIENT MEDICAID NUMBER 12345678	7. REMITTANCE ADVICE DATE 09/10/2004
5. PROVIDER LABEL Second Street Hospital #019999999 486 Second Street First City, MO 80000	8. R.A. PAGE NUMBER 25

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT	08/04/2004	$1,132.00	$0.00
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			

15. OTHER/REMARKS

Billed Medicaid in error before billing commercial insurance. Please take back payment.

HELPFUL HINTS FOR FILING AN ADJUSTMENT REQUEST FORM

1. **Only one internal control number (claim) is allowed per request.**
2. **Only a *paid* claim can be adjusted. A denied claim *cannot* be adjusted (file a new claim with the corrected information on it.).**
3. **If you want Medicaid to recoup an entire payment, *do not* enter each line of the claim. Instead, complete the top of the form and line 12 only. Enter the date of service, the amount Medicaid paid, and a "0" in the corrected information field.**
4. **When a change to a claim is necessary, such as a service date or quantity, use the ICN of the claim that paid and file an adjustment request. Do not send a new claim as it will deny as a duplicate.**
5. **An ICN beginning with a "70" or "75" credits or recoups the original paid claim. An ICN beginning with a "50" or "55" repays the claim with the corrected information.**
6. **Use the 'Remarks" section of the form to explain the reason for the correction.**

16. PROVIDER'S SIGNATURE	TITLE	DATE
		10/13/2004

MO 886-1019E (4-96)

MO 8810

SECTION 7

MEDICARE BILLING TIPS

CLAIMS NOT CROSSING OVER ELECTRONICALLY

If none of a provider's Medicare claims are crossing over to Medicaid electronically, contact Medicaid to see if the provider has a Medicare number on file and that it is the correct one. Although Medicare advises that a claim was forwarded to Medicaid for processing, this does not guarantee that Medicaid received the claim information or was able to process it. If there is a problem with the claim or the recipient or provider files, the claim will not process. **A provider should wait 60 days from the date a claim was paid by Medicare before filing a crossover claim with Medicaid.** If a claim is submitted sooner, it is possible that the provider will receive a duplicate payment. If this occurs, the provider must submit an Individual Adjustment Request form to have Medicaid take back one of the payments.

TIMELY FILING

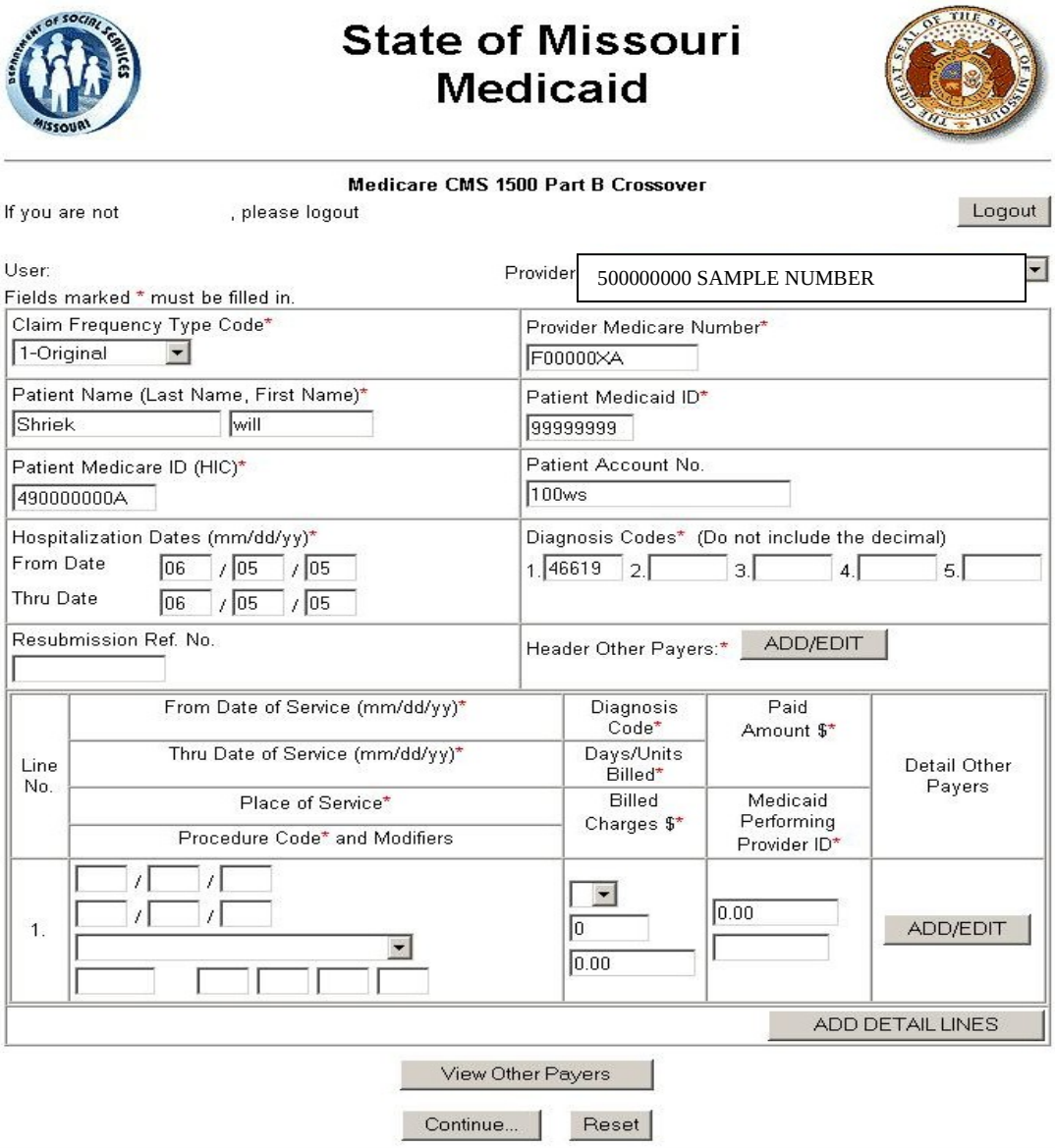
Claims initially filed with Medicare within Medicare timely filing requirements and that require separate filing of a crossover claim with Medicaid must meet the timely filing requirements by being submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever date is *later*. The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.

BILLING FOR ELIGIBLE DAYS

A provider may attempt to bill only for eligible days on the Medicaid Part B claim form. In order for crossover claims to process correctly, a provider must bill all dates of service shown on the Medicare EOMB. The Medicaid claims system will catch those days' claims containing ineligible days and the claim will be prorated for the eligible days only.

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid should be adjusted using an Individual Adjustment Request form with both Medicare EOMBs attached to the form.



State of Missouri
Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider 500000000 SAMPLE NUMBER

Fields marked * must be filled in.

Claim Frequency Type Code* 1-Original	Provider Medicare Number* F00000XA
Patient Name (Last Name, First Name)* Shriek will	Patient Medicaid ID* 99999999
Patient Medicare ID (HIC)* 490000000A	Patient Account No. 100ws
Hospitalization Dates (mm/dd/yy)* From Date 06 / 05 / 05 Thru Date 06 / 05 / 05	Diagnosis Codes* (Do not include the decimal) 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	Header Other Payers:* ADD/EDIT

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Other Payers
1.	/ / / / /	0 / 0.00	0.00	ADD/EDIT

ADD DETAIL LINES

View Other Payers

Continue... Reset

- **At the Medicaid billing Web site, click on 'Medicare CMS 1500 Part B Crossover. That will bring you to the screen above.**
- **Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions;**
- **Scroll back to the top of the form and complete all the Medicaid header information. Refer to the Medicare EOMB on the previous page as well as the patient's medical record. Complete the fields as shown above, then complete the Header Other Payer by clicking on 'ADD/EDIT'.**

Please turn the page.

State of Missouri Medicaid

Other Payer Header Information

Enter Other Payer(s) Header Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Other Payer #1

Filing Indicator*	MB-Medicare	Other Payer Name*	Medicare Part B
Paid Amount $	25.88	Paid Date (mm/dd/yy)*	06 / 29 / 05
Medicare Claim No.	05167000000000		
Header Allowed Amount $ *	32.35	Total Denied Amount $	0.00

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $

Add Reason Codes

Remark Codes					

Remove Payer #1

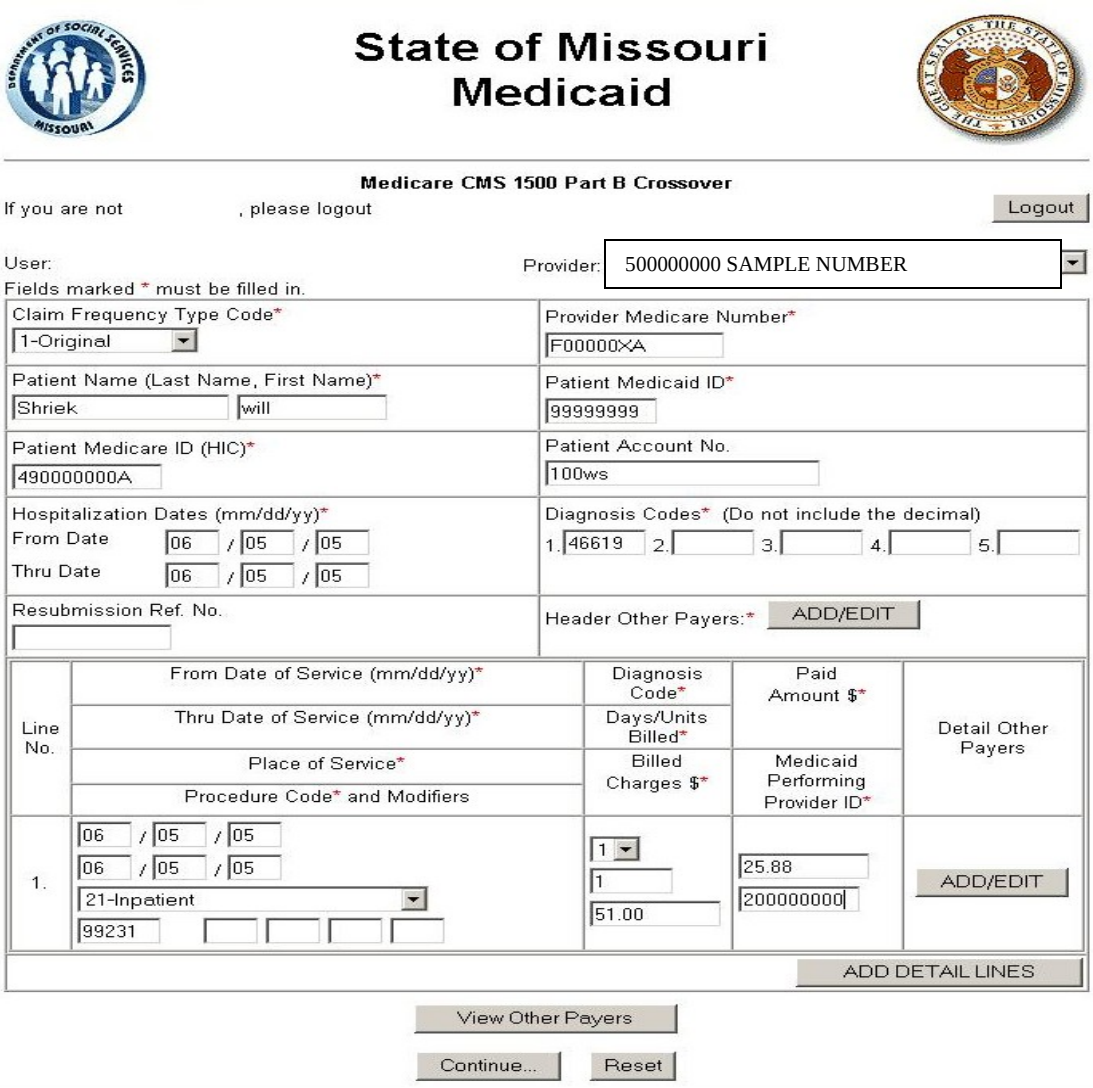
Add Payer

Done Cancel

[Help]

- **Now you are on the Other Payer Header screen. Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
- **Scroll back to the top of the form and complete the information at the top as shown. For Part B and Part B of A crossover claims, you do not complete the Group Codes, Reason Codes and Adjustment Amounts information. You will be entering this information elsewhere.**
- **Click on 'Done'.**

Please turn the page.



State of Missouri Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout — Logout

User: Provider: 500000000 SAMPLE NUMBER

Fields marked * must be filled in.

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: F00000XA
Patient Name (Last Name, First Name)*: Shriek, will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.: 100ws
Hospitalization Dates (mm/dd/yy)*: From Date 06/05/05; Thru Date 06/05/05	Diagnosis Codes* (Do not include the decimal): 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.	Header Other Payers:* ADD/EDIT

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Other Payers
1.	06/05/05; 06/05/05; 21-Inpatient; 99231	1; 1; 51.00	25.88; 200000000	ADD/EDIT

ADD DETAIL LINES

View Other Payers

Continue... Reset

- **Now you are back on the original screen ready to add your detail information to the claim.**
- **Again, using the Medicare EOMB example from the previous page, enter the detail information as shown above.**
- **When done entering the information, click on 'ADD/EDIT' to add the Medicare detail information.**

Please turn the page.

State of Missouri Medicaid

Other Payer Detail Information

Enter Other Payer(s) Detail Information for Medicare CMS 1500 Part B Crossover claim.

Fields marked * must be filled in.

Claim Detail Line #1

Other Payer #1

Paid Date (mm/dd/yy)* 06 / 29 / 05

Group Codes, Reason Codes & Adjustment Amounts

Group Code	Reason Code	Adjust Amount $	Group Code	Reason Code	Adjust Amount $
CO-Contractual Obligation	042	18.65	PR-Patient Responsibility	002	6.47

Add Reason Codes

Remove Payer #1

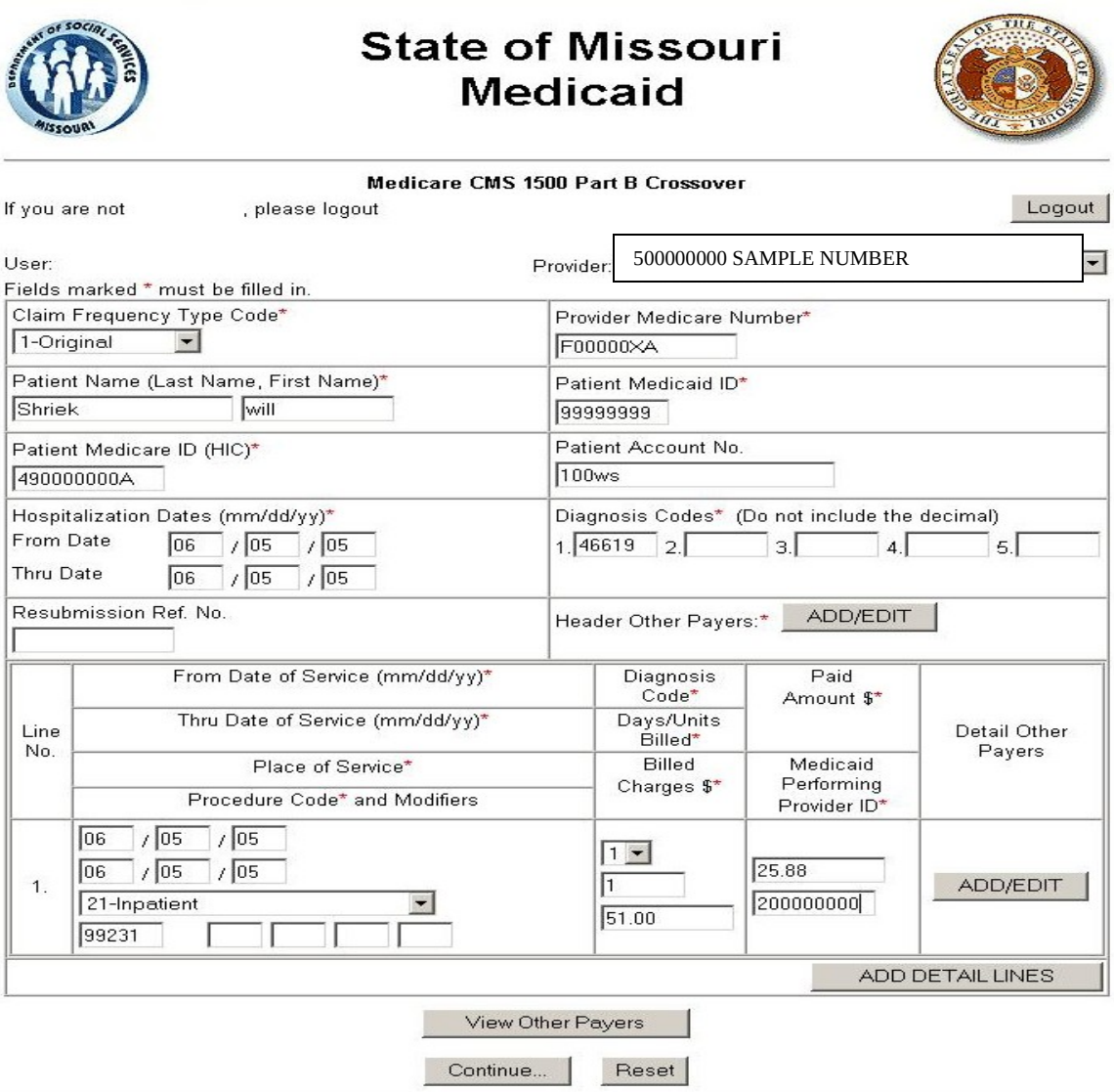
Add Payer

Done Cancel

[Help]

- **Now you are on the Other Payer Detail screen. Scroll to the bottom of the form and click on the 'Help' button, print off and save the instructions.**
- **Scroll back to the top, complete the Medicare paid date information as well as the Group and Reason Codes and Adjustment Amounts. See above sample. If the reason codes are not listed on your Medicare EOMB, choose the most appropriate code from the list of "Claim Adjustment Reason Codes" from the HIPAA Related Code List. For example, the code on the Claim Adjustment Reason Code list for deductible amount is 1 and for coinsurance amount is 2. Therefore, you would enter a Reason Code of '001' for deductible amounts and '002' for coinsurance amounts due.**
- **The 'Adjust Amount' should reflect any amount not paid by Medicare including deductible, coinsurance and any non-allowed amounts.**
- **Click on 'Done'.**

Please turn the page.



State of Missouri Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000 SAMPLE NUMBER

Fields marked * must be filled in.

Claim Frequency Type Code*: 1-Original	Provider Medicare Number*: F00000XA
Patient Name (Last Name, First Name)*: Shriek, will	Patient Medicaid ID*: 99999999
Patient Medicare ID (HIC)*: 490000000A	Patient Account No.: 100ws
Hospitalization Dates (mm/dd/yy)*: From Date 06 / 05 / 05; Thru Date 06 / 05 / 05	Diagnosis Codes* (Do not include the decimal): 1. 46619 2. 3. 4. 5.
Resubmission Ref. No.:	Header Other Payers:* ADD/EDIT

Line No.	From Date of Service (mm/dd/yy)* / Thru Date of Service (mm/dd/yy)* / Place of Service* / Procedure Code* and Modifiers	Diagnosis Code* / Days/Units Billed* / Billed Charges $*	Paid Amount $* / Medicaid Performing Provider ID*	Detail Other Payers
1.	06 / 05 / 05; 06 / 05 / 05; 21-Inpatient; 99231	1; 1; 51.00	25.88; 200000000	ADD/EDIT

ADD DETAIL LINES

View Other Payers

Continue... Reset

- **This brings you back to the original screen. At this point, we are done entering the information. Click on 'Continue'.**

Please turn the page.

State of Missouri Medicaid

Medicare CMS 1500 Part B Crossover

If you are not , please logout Logout

User: Provider: 500000000

Please verify the values entered and click the Edit or Submit button.

Claim Frequency Type Code 1	**Provider Medicare Number** F00000XA
Patient Name (Last Name, First Name) Shriek, will	**Patient Medicaid Id** 99999999
Patient Medicare ID (HIC) 490000000A	**Patient Account No.** 100ws
Hospitalization Dates (mm/dd/yy) **From Date** 06/05/05 **Thru Date** 06/05/05	**Diagnosis Codes** 46619
Resubmission Ref No.	**Header Other Payers:** *Click 'View Other Payers'*

Line No.	From Date of Service (mm/dd/yy)	Diagnosis Code	Paid Amount $	Detail Other Payers
	Thru Date of Service (mm/dd/yy)	Days/Units Billed		
	Place of Service	Billed Charges $	Medicaid Performing Provider ID	
	Procedure Code and Modifiers			
1.	06/05/05	1	25.88	*Click 'View Other Payers'*
	06/05/05	1		
	21	51.00	200000000	
	99231			

View Other Payers

Edit Submit

[Home] [Help]

- **This brings you to a screen asking you to verify the information entered. Scroll to the bottom of the screen and click 'Help', print off and save the instructions.**
- **You can either edit the information or submit. Click on 'Submit'.**

Please turn the page.

State of Missouri Medicaid

Medicare CMS 1500 Part B Crossover

If you are not [redacted], please logout Logout

User: [redacted] Provider: 50000000

Thank you. Your claim has been received.

Claim Frequency Type Code 1	**Provider Medicare Number** F00000XA
Patient Name (Last Name, First Name) Shriek, will	**Patient Medicaid Id** 99999999
Patient Medicare ID (HIC) 490000000A	**Patient Account No.** 100ws
Hospitalization Dates (mm/dd/yy) **From Date** 06/05/05 **Thru Date** 06/05/05	**Diagnosis Codes** 46619
Resubmission Ref No.	**Header Other Payers:** *Click 'View Other Payers'*

Line No.	From Date of Service (mm/dd/yy)	Diagnosis Code	Paid Amount $	Detail Other Payers
	Thru Date of Service (mm/dd/yy)	Days/Units Billed		
	Place of Service	Billed Charges $	Medicaid Performing Provider ID	
	Procedure Code and Modifiers			
1.	06/05/05	1	25.88	*Click 'View Other Payers'*
	06/05/05	1		
	21	51.00	200000000	
	99231			

View Other Payers

Next Print

[Home] [Help]

- **After submitting your claim, you will be brought to a screen which states, "Thank you. Your claim has been received". Click on the 'Print' button at the bottom of the screen to print off and save for your records.**
- **To enter another claim, click on 'Next'.**

SECTION 8
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Ingenix Publications
P.O. Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

Medicaid also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
http://pmiconline.com

SECTION 9
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

MEDICAID RECIPIENT REIMBURSEMENT (MMR)

The Medicaid Recipient Reimbursement program (MMR) is devised to make payment to those recipients whose eligibility for Medicaid benefits has been denied and whose eligibility is subsequently established as a result of an agency hearing decision, a court decision based on an agency hearing decision, or any other legal agency decision rendered on or after January 1, 1986.

Recipients are reimbursed for the payments they made to providers for medical services received between the date of their denial and the date of their subsequent establishment of eligibility. The recipient is furnished with special forms to have completed by the provider(s) of service. If Medicaid recipients have any questions, they should call (800) 392-2161.

SECTION 10
FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services, and supplies require the submission of a form before a claim can be processed for payment. Please note that several of the forms can be submitted electronically through the Infocrossing Internet service at www.emomed.com.

Acknowledgement of Receipt of Hysterectomy Information
Second Surgical Opinion
Sterilization Consent

If a form is submitted electronically, the provider **must** keep a paper copy of the form in the patient's medical record.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 800/392-0938 or 573/751-2896.
- Go to the Medicaid website, www.dss.mo.gov/dms, and select and click on "forms" under Provider Information.
- Use the Infocrossing order form found at the end of this section.

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

PSYCHOLOGICAL SERVICES REQUEST FOR PRIOR AUTHORIZATION

Authorization approves the medical necessity of the requested service only. It does not guarantee payment. The recipient must be Medicaid eligible on the date of service.

RECIPIENT NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	PROVIDER NAME (AFFIX LABEL HERE)
RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE	MEDICAID NUMBER	ADDRESS
☐ INITIAL REQUEST ☐ *CONTINUED TREATMENT		MEDICAID PROVIDER NUMBER

PROVIDER TELEPHONE NO.	PROVIDER FAX NO.	SIGNATURE	DATE

1. Has the patient/guardian agreed to his/her treatment plan? ☐ Yes ☐ No
2. Have you communicated with the PCP or other relevant health care practitioners about treatment? ☐ Yes ☐ No ☐ No Release ☐ No PCP
3. Are you requesting Family Therapy be conducted? ☐ Yes Provider# _____ ☐ No
4. Are you requesting Group Therapy be conducted? ☐ Yes Provider# _____ ☐ No
5. Are you requesting assessment hours? ☐ Yes Hours _____ ☐ No
6. Are you requesting diagnostic testing? ☐ Yes Hours _____ ☐ No

DSM-IV-TR MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE)

AXIS I: CLINICAL DISORDERS OR OTHER CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTIONS

DIAGNOSTIC CODE	DIAGNOSTIC CODE
___ ___ ___ . ___ ___	___ ___ ___ . ___ ___

IS THERE ANY EVIDENCE OF SUBSTANCE ABUSE?
☐ Yes ☐ No

AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION

DIAGNOSTIC CODE	DIAGNOSTIC CODE
___ ___ ___ . ___ ___	___ ___ ___ . ___ ___

AXIS III: GENERAL MEDICAL CONDITIONS

DOES THIS PATIENT HAVE A CURRENT GENERAL MEDICAL CONDITION THAT IS POTENTIALLY RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE CONDITION(S) NOTED IN AXIS I OR II?

☐ Yes ☐ No If Yes, list condition: _____

AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS (PLEASE INDICATE ALL THAT APPLY)

☐ Problems with primary support group
☐ Problems related to social environment
☐ Problems with access to health care services
☐ Other psychosocial and environmental problems
☐ Problems related to interaction with legal system/crime
☐ Economic problems
☐ Educational problems
☐ Occupational problems
☐ Housing problems
☐ None

AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING SCALE (GAF)

SCORE	DATE

SERVICE INFORMATION

(This area to be used only if the patient is between the ages of 0-2 or if Family Therapy without the patient present)

REF. NO.	PROCEDURE CODE	MODIFIER 1	MODIFIER 2	FROM	THROUGH	DESCRIPTION OF SERVICE/ITEM	QTY. OR UNITS	FOR STATE USE ONLY APPROVED	FOR STATE USE ONLY DENIED
1									
2									
3									

** Requires an initial assessment, treatment plan and the last three progress notes. Continued treatment requests may only be made after 75% of the current PA is used.*

MO 886-4140 (9-04)

INSTRUCTIONS FOR COMPLETION

HEADER INFORMATION

Recipient Name – Enter the recipient's name as it appears on the Medicaid ID card.

Date of Birth – Enter the recipient's date of birth.

Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.

Recipient Address – Enter the recipient's current address.

Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.

Provider Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.

Initial Request/Continued Treatment – Mark *Initial* for the first Prior Authorization (PA) requested after the 4 hours service without PA. Mark *Continued Treatment* for any PA requested after the initial PA. After the initial/first PA, the second and all future requests require copies of the original assessment, the treatment plan, and the last three progress notes attached to the Prior Authorization Request Form.

Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.

Provider Phone – Enter current phone number of the provider making the request.

Provider Fax Number – Enter the fax number of the provider making the request.

Signature/Date – The provider of services should sign the request and indicate the date the form was completed.

QUESTIONS NUMBER 1 THROUGH 6 MUST BE COMPLETED. A SEPARATE PA MUST BE REQUESTED FOR NUMBERS 3 AND 4. HOURS FOR ASSESSMENT AND DIAGNOSTIC TESTING MUST BE LISTED IN ORDER TO BE REIMBURSED.

DSM-IV-TR MULTIAXIAL DIAGNOSIS MUST BE COMPLETED

Axis I – Clinical Disorders

Axis II – Personality Disorders, Mental Retardation

Axis III – General Medical Conditions

Axis IV – Psychosocial and Environmental Problems

Axis V – Global Assessment of Functioning

SERVICE INFORMATION – This field is only to be used for psychological services for children under 3 years of age and Family Therapy without Patient Present.

1). Ref. No. – (Reference Number) A unique designator (1-4) identifying each separate line on the request.

2). Procedure Code – Enter the behavioral therapy procedure code being requested here.

3). Modifier 1 and Modifier 2 – If appropriate, enter the modifier that goes with the corresponding procedure code here.

4). From – Enter the from date that service will begin if authorization is approved (mm/dd/yy format).

5). Through – Enter the through date that the service will terminate if authorization is approved (mm/dd/yy format).

6). Description of Service/Item – Enter a specific description of the service/item being requested.

7). Quantity or Units – Enter the quantity or units of service/item being requested.

STATE USE ONLY – Leave Blank

Prior authorization request may be phoned, faxed or mailed into the call center (see below)

Verizon
P.O. Box 4800
Jefferson City, MO 65102
Phone (toll free) 866-771-3350
Fax 573-635-6516

MO 886-4140 (9-04)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO NOT SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER	DATE (MM / DD / YY)
___ ___ ___ ___ ___ ___ ___ ___ ___	
PROVIDER NAME	

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION

☐ ADD NEW RESOURCE OR ☐ CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME	MEDICAID I.D. NUMBER
	___ ___ ___ ___ ___ ___ ___ ___
INSURANCE COMPANY NAME	
POLICYHOLDER (IF OTHER THAN RECIPIENT)	POLICYHOLDER'S SOCIAL SECURITY NUMBER
POLICY NUMBER	GROUP NAME OR NUMBER

VERIFIED INFORMATION

_____

_____

SOURCE OF VERIFIED INFORMATION: ☐ EMPLOYER ☐ INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT	DATE CONTACTED (MM / DD / YY)
( )	
NAME OF PERSON COMPLETING THIS FORM	TELEPHONE NUMBER

Do you want confirmation of this add/update?
(If yes, you **must** complete the name and address on back) ☐ YES ☐ NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

MO 886-2983 (2-97)

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

_____

_____

_____

TO BE COMPLETED BY THE STATE

❑ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

❑ Please resubmit claims

❑ Form not complete enough for verification by state - complete highlighted areas and resubmit

❑ TPL file already reflects the add/update. Our records were updated: _____

❑ Verification confirms Medicaid resource file correct as is - no update performed

❑ Change requested cannot be made. Reason:

_____

_____

_____

❑ Verification shows another current coverage that may be applicable:

_____

_____

_____

❑ Other: _____

_____

_____

_____

MO 886-2983 (2-97)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK ******SEE INSTRUCTIONS ON REVERSE SIDE******

SECTION A **(All providers must complete this section)**

1.TYPE OF DIRECT DEPOSIT ACTION➨ □ New provider/Re-enrollment ✦□ Cancel Direct Deposit ✦□ Change Account/Route number

2.PROVIDER NAME: Complete provider name below as shown on provider labels. **If the Application for Provider Direct Deposit is for a clinic or group,** this form must be accompanied by an Authorization by Clinic Members which **must** contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the **ORIGINAL** signature of the clinic owner or administrator. All other providers **MUST** complete a **separate** Application for Provider Direct Deposit containing their individual provider number and ***original*** signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. **A separate Application for Provider Direct Deposit must be completed for each provider number assigned.**

TYPE OR PRINT PROVIDER NAME HERE ➨

3.PROVIDER NUMBER (enter provider number as shown on provider label, **one provider number per application**)

____ ____ ____ ____ ____ ____ ____ ____ ____

SECTION B **(Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.)**
(ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below.
The information completed on this form and the information on the attachment MUST match.

1. ROUTING NUMBER	2. DEPOSITOR ACCOUNT NUMBER
_____	_____

3. TYPE OF ACCOUNT (***must check one***) ➨ □ CHECKING ✦ □ SAVINGS

4. FINANCIAL INSTITUTION NAME	5. BRANCH NUMBER OR NAME (if applicable)
6. FINANCIAL INSTITUTION ADDRESS	7. TELEPHONE NUMBER (include area code)

SECTION C

I wish to participate in Direct Deposit and in doing so:

- ✦ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- ✦ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any **credit entries made in error** to my account designated above.
- ✦ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- ✦ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.
- ✦ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- ✦ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above.
- ✦ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ❑ **I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION** and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. ***(Section A number 1 must also be completed)***

2. PROVIDER *ORIGINAL* SIGNATURE (*see requirements on reverse side of this form*)	TYPE OR PRINT NAME SIGNED & TITLE	3.DATE	4.TELEPHONE NUMBER

RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ***ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO:*** Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617

THIS FORM CANNOT BE FAXED

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

1. **Type of Direct Deposit Action** -Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. **Provider Name and Provider Number** - Enter provider name **and** number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION CHECK NO.4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 8765432109812 4444

↕ Routing No. ↕ Depositor Acct No. ↕ Check No.

EXAMPLE 2

FINANCIAL INSTITUTION CHECK 4444
HOMETOWN, USA

PAY TO ORDER OF _____

121456789 4444 8765432109812

↕ Routing No. ↕ Check No. ↕ Depositor Acct No.

*********Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*********

SECTION C

1. **TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the *CANCEL* box if you wish to *CANCEL* your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to ***cancel or redesignate*** your account and/or financial institution.
   DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain** a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. **The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete** a separate Application for Provider Direct Deposit containing their individual provider number and **original** signature. **A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

1. **ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.
2. Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
4. The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

Forms Request

Provider Number: _____ Date: _____
(Or Affix Provider Label Here)

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity Preprinted	Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS	Quantity
J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

_____
* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev. 11/00)

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

Director, Department of Social Services

2004
Year